Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HEALTHTRUST
P O BOX 890008
HOUSTON TX 77289

Respondent Name

LIBERTY MUTUAL FIRE INSURANCE COMPANY

Carrier's Austin Representative Box

Box Number 01

MFDR Tracking Number

M4-12-0407-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier gave preauthorization for 6 sessions of individual psychotherapy as you will see in the attached documentation. The carrier has paid for 4 of the 6 sessions. There was no notice of any issues of compensability or relatedness noted in the preauthorization as dictated by the Texas Code." "The carrier based their denial on their assumption that the performed services are not considered medically necessary by a retrospective peer review. However, Rule 133.301(a) states that in regards to Retrospective Review of Medical Bills, that once preauthorization is granted, medical necessity has been established and if the claim is denied retrospectively for medical necessity, the carrier is in violation of this rule. This also includes the idea that once preauthorization has been granted and medical necessity has been established, this cannot be rescinded retrospectively, even with a peer review."

Amount in Dispute: $295.12

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to the requestors request for medical fee dispute resolution.

Response Submitted by: N/A

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 23, 2011 and June 16, 2011	90806 X 2 DOS	$295.12	$282.07

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.600 sets out guidelines for preauthorization, concurrent review, and voluntary certification of health care.
3. 28 Texas Administrative Code §134.203 set out the fee guideline s for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated June 28, 2011
   - W9 (X435) – BASED ON PEER REVIEW, FURTHER TREATMENT IS NOT RECOMMENDED. FOR TEXAS JURISDICTION CLAIMS ONLY, PER TEXAS LABOR CODE SECTION 413.031 AND 28 TEX. ADMIN. CODE SECTIONS 133.308(H), (I), AFTER RECONSIDERATION, YOU MAY SEEK REVIEW OF A DENIAL OF MEDICAL NECESSITY THROUGH THE TDI-DWC-APPOINTED INDEPENDENT REVIEW ORGANIZATION. THE FORM TO INITIATE THIS PROCESS CAN BE OBTAINED FROM THE DIVISION WEBSITE AT WWW.TDI.STATE.TX.US AND MUST BE SENT VIA FAX TO 603-334-8064. (X435)

   Explanation of benefits dated July 23, 2011
   - W9 (X435) – BASED ON PEER REVIEW, FURTHER TREATMENT IS NOT RECOMMENDED. FOR TEXAS JURISDICTION CLAIMS ONLY, PER TEXAS LABOR CODE SECTION 413.031 AND 28 TEX. ADMIN. CODE SECTIONS 133.308(H), (I), AFTER RECONSIDERATION, YOU MAY SEEK REVIEW OF A DENIAL OF MEDICAL NECESSITY THROUGH THE TDI-DWC-APPOINTED INDEPENDENT REVIEW ORGANIZATION. THE FORM TO INITIATE THIS PROCESS CAN BE OBTAINED FROM THE DIVISION WEBSITE AT WWW.TDI.STATE.TX.US AND MUST BE SENT VIA FAX TO 603-334-8064. (X435)

   Explanation of benefits dated September 12, 2011
   - W9 (X435) – BASED ON PEER REVIEW, FURTHER TREATMENT IS NOT RECOMMENDED. FOR TEXAS JURISDICTION CLAIMS ONLY, PER TEXAS LABOR CODE SECTION 413.031 AND 28 TEX. ADMIN. CODE SECTIONS 133.308(H), (I), AFTER RECONSIDERATION, YOU MAY SEEK REVIEW OF A DENIAL OF MEDICAL NECESSITY THROUGH THE TDI-DWC-APPOINTED INDEPENDENT REVIEW ORGANIZATION. THE FORM TO INITIATE THIS PROCESS CAN BE OBTAINED FROM THE DIVISION WEBSITE AT WWW.TDI.STATE.TX.US AND MUST BE SENT VIA FAX TO 603-334-8064. (X435)
   - X598 – CLAIM HAS BEEN RE-EVALUATED BASED ON ADDITIONAL DOCUMENTATION SUBMITTED; NO ADDITIONAL PAYMENT DUE. (X598)

   Explanation of benefits dated September 15, 2011
   - W9 (X435) – BASED ON PEER REVIEW, FURTHER TREATMENT IS NOT RECOMMENDED. FOR TEXAS JURISDICTION CLAIMS ONLY, PER TEXAS LABOR CODE SECTION 413.031 AND 28 TEX. ADMIN. CODE SECTIONS 133.308(H), (I), AFTER RECONSIDERATION, YOU MAY SEEK REVIEW OF A DENIAL OF MEDICAL NECESSITY THROUGH THE TDI-DWC-APPOINTED INDEPENDENT REVIEW ORGANIZATION. THE FORM TO INITIATE THIS PROCESS CAN BE OBTAINED FROM THE DIVISION WEBSITE AT WWW.TDI.STATE.TX.US AND MUST BE SENT VIA FAX TO 603-334-8064. (X435)
   - X598 – CLAIM HAS BEEN RE-EVALUATED BASED ON ADDITIONAL DOCUMENTATION SUBMITTED; NO ADDITIONAL PAYMENT DUE. (X598)

Issues

1. Did the requestor obtain preauthorization approval prior to providing the health care in dispute in accordance with 28 Texas Administrative Code §134.600?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code, Section §133.240(b) states, "For health care provided to injured employees not subject to a workers' compensation health care network established under Insurance code Chapter 1305, the insurance carrier shall not deny reimbursement based on medical necessity for health care preauthorized or voluntarily certified under Chapter 134 of the title (relating to Benefits—Guidelines for Medical Services, Charges, and Payments." 28 Texas Administrative Code, Section §134.600(c)(1)(B) states, "The carrier is liable for all reasonable and necessary medical costs relating to the health care required to treat a compensable injury…only when the following situations occur…preauthorization of any health care listed in subsection (p) of this section was approved prior to providing the health care." Review of the submitted preauthorization letter dated April 22, 2011 supports the provider obtained preauthorization for the disputed

services of May 23, 2011 and June 16, 2011 prior to providing the health care. Therefore, reimbursement is recommended for these disputed dates of service.

2. 28 Texas Administrative Code, Section §134.203(b) and (c) stated in pertinent part, " for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply…Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules." To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications; for service categories of Evaluation Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting." The 2011 Division conversion factor to be applied is $54.54. The MAR for CPT code 90806 is as follows: DWC conversion factor of $54.54 divided by Medicare conversion factor of 33.9764 = $1.605 X Participating amount of $87.86 = $141.035 X 2 DOS = $282.07. This amount is recommended for reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $282.07.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $282.07 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 7, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.